

Conducting A Thorough Investigation

Federal guidelines require that a facility **must** have evidence that all allegations of abuse, neglect and misappropriation of resident property, including injuries of unknown source, have been thoroughly investigated. In addition, the facility **must** take action to prevent further potential abuse while the investigation is in progress.

483.13(b)(c) F223, F224, F225, F226

The following guidance represents the components of an investigation that would constitute a “thorough investigation.” The facility should document all aspects of their investigation in order to provide evidence that all allegations were thoroughly investigated.

Drawing a *reasonable inference* or an *assumption* about what happened does not negate the requirements for a thorough investigation and reporting of the incident.

The Investigation

1. Identify the type of reportable incident (injury of unknown source or alleged abuse).
2. If abuse is alleged, identify the type of abuse (i.e., physical, verbal, sexual, mental, neglect, involuntary seclusion, misappropriation of resident property).
3. If the reportable incident is an injury of unknown source (refer to CMS S&C 05-09), describe the injury. Document the size, location, color, pattern and number of injuries. What treatment was required and provided? Document if the resident has had similar injuries. Identify any diagnoses or medications that have the potential for placing the resident at risk for injury.
4. Consider and document the time of the last observation of the resident prior to the reportable incident. What was the resident’s condition prior to the reportable incident? What was the resident’s condition after the reportable incident?
5. If the reportable incident is a case of suspected abuse, examine the resident for any signs of injury. Was there a change in the resident’s “usual” demeanor? Accurately describe the first signs of injury or any change in the resident. Photograph any actual injury in a manner that will show a close-up view of the injury and will not include the resident’s face or other identifying features. The staff taking the photographs should sign and date the photographs and document the name of the resident on the photograph.
6. Interview the person reporting the incident. Was the incident reported timely? What allegedly occurred? When and where did the alleged incident occur? If abuse is alleged, has an individual been identified as the abuser?

7. Develop a list of known and possible witnesses to the reportable incident. Interview staff, residents, and/or visitors, or anyone who has or might have knowledge of the incident under investigation. Interview staff assigned to the resident at the time of the alleged incident. In addition, consider all possible witnesses such as housekeeping and dietary staff. Interview staff on other shifts that may have seen or heard something, such as 24 to 48 hours prior to the identification of the reportable incident. Attempt to narrow down the time of the alleged incident. Interview the resident in the same room, or residents in the immediate vicinity where the reportable incident occurred. Consider who may have seen or heard something and what they think could have happened. Observe and document any unusual demeanor of the person being interviewed
8. Identify the cognitive status of the victim(s) and resident(s) determined to be witnesses. Are they alert and oriented and able to answer questions appropriately? Can staff confirm the resident's ability to be an accurate reporter of the events? If so, document the interview with the staff related to the reliability of the resident. Review a copy of the resident's current MDS and the current plan of care, if applicable to the incident. If the witness (resident or roommate) is not alert and oriented, but the facility is utilizing the resident's statement in the investigation, explain why the resident is considered an accurate reporter (i.e., he/she has a history of consistently providing accurate information).
9. Obtain written, signed, double witnessed or notarized statements from the reporter and all other identified witnesses. If possible, obtain written statements from the resident who was the subject of the reportable incident and from any other residents you have identified as possible witnesses, including the resident's roommate. Review the statements for the use of vague allegations (i.e., "rough treatment" or "treated me ugly"). If the statements contain vague allegations, have the witness write a more detailed description of what allegedly occurred. Statements taken from actual eyewitnesses should be very specific, and should contain the witness's name, address, and phone number. Review and compare all the witness statements for conflicting information (i.e., dates, times, location, other staff present). Every statement should be witnessed and/or notarized at the time the statement is made. If no one else was present at the time the statement was made, assure the person writing the statement confirms to a witness or notary that the statement is his/her own, that the statement is accurate, and that the handwriting and/or signature on the statement is his/her own. If the writer confirms this in person to a witness/notary, then that person may sign as a witness/notary. Has a person been identified as the "abuser"? Interview and inform the alleged abuser of alleged accusations and obtain a written statement.
10. Review and have documentation of the "as worked schedule" for the 48-hour period prior to and the day of the reportable incident. When and where was the alleged abuser(s) working at the time of the incident? Be specific as to the hall, section, and room numbers. Review and compare the "as worked schedule" and

the witness statements for accuracy of pertinent dates, times, location, and persons present.

11. Review the alleged abuser(s) personnel record for a history of previous disciplinary actions, previous employment evaluations, background investigation, inservice record, and the status of the certification or license. Interview co-workers and/or residents to gain knowledge of their experiences with the alleged abuser(s).
12. Document any action(s) taken by the facility to protect the resident and to prevent possible retaliation during the investigation (maintain punch card reports to show alleged abuser(s) was suspended during the investigation).
10. Document any knowledge of bias between alleged abuser(s) and witnesses. What is the relationship between the witnesses and the alleged abuser(s) (i.e., professionals, friends, relatives, and enemies)? Is there a reason the witness would wrongfully accuse the alleged abuser?
11. Were agency personnel involved? Obtain a written, dated, signed, double witnessed or notarized statement. Identify the name of the agency, the contact person, and the names, address, and phone number of the agency staff employee(s).
12. **If the allegation involves alleged sexual abuse**, did a nurse immediately examine the resident? Did the nurse document the findings? Document if a physician examined the resident and maintain a copy of the examination. Document specifically what immediate action was taken by the staff at the time of the alleged abuse, i.e., facility secured, notification of administrator, physician, responsible party, law enforcement, evidence secured (resident's clothing not removed, resident not bathed). Follow "thorough investigation" protocol.
13. **If the allegation involves neglect**, attempt to identify the staff involved. How were they involved and what was the outcome to the resident? Maintain physical evidence related to the care of the resident in use **on the day of the incident** (i.e., written plan of care, communication tools used to direct care such as signs above the head of the bed, personal care records, CNA assignments sheets, facility communication sheets). Sign and date copies of any forms or documents used in the care of the resident at the time of the incident. If applicable, review facility procedures if the incident may be related to unsafe technique. Review and maintain the manufacturer's recommendations related to the use of special equipment. Review and identify any nurse's notes or other facility records that may contain information relative to the incident. What interventions were in place prior to the reportable incident? Follow "thorough investigation" protocol.

14. **If the allegation involves misappropriation of resident property**, clearly identify the missing items and their approximate value. Document the immediate action taken, i.e. notification of law enforcement, responsible party. Obtain copies of bills, charge slips, vendor receipts. Follow “thorough investigation” protocol.

15. **Facility Investigative File:** At the onset of the investigation, begin compiling the investigative file, to be maintained as a record. A complete investigative file may contain/but is not limited to the following:
 - a. Reporting sheets completed by staff to internally report the incident (i.e., Incident and Accident Report), as well as reporting documents as evidence of appropriate reporting to the state survey agency (i.e. Initial 24-Hour Report and Five-Day Follow-Up Report).
 - b. Witness statements for all witnesses, alleged abuser(s), and resident if applicable. Include written statements not only from everyone involved in the incident but also everyone who participated in any way in the investigation.
 - c. Any written documentation related to an actual injury, (i.e., nurses notes, social work notes on the day of the incident and any other related dates), as well as pictures of the actual injury that identify the resident by name only, signed and dated by the staff member taking the photographs.
 - d. Related physician’s orders, such as an order for a particular transfer device, or for x-rays if there is evidence or suspicion of injury.
 - e. The Resident Care Plan signed and dated by staff to show the care plan that was in place at the time of the incident.
 - f. Documents that serve as instruction to CNAs related to the care of the resident (i.e., CNA B.E.T.T.E.R. Tool, daily communication sheets, etc.). This document should be signed and dated to confirm the document was in use at the time of the incident.
 - g. Manufacturer’s recommendations related to the use of special equipment.
 - h. Inservice material with sign-rosters for equipment in use at the time of the injury that may potentially be involved in the cause of the injury (i.e., lift, transfer equipment, etc.). Include inservice and orientation records that show the staff was trained on any equipment related to the injury.
 - i. “As-Worked” schedule for all staff on the unit at the time of the injury and 24 to 48 hours prior to the injury. This document should be signed and dated to confirm the document was in use at the time of the incident.

- j. Assignment sheets for staff caring for the resident at the time of the incident. This document should be signed and dated to confirm the document was in use at the time of the incident.
- k. Documents that show action taken by the facility to protect the resident (i.e., Punch Card Detail for alleged abuser).
- l. Name(s) of agency personnel on duty at the time of the incident. Include the name of the agency, the contact person, and the names, addresses and phone numbers of all agency staff employee(s).
- m. Documentation of disciplinary action of the alleged abuser(s) at the time of the incident and any other time during their employment with the facility. Include a copy of the background investigation prior to hire, and the current certification or license.
- n. Documentation of any notification/referrals made as a result of the investigation such Board of Nursing or law enforcement.

Summary Report of Facility Investigation

Upon conclusion of the investigation, the facility should prepare a report to include details of the investigation, any actions taken by the facility (i.e., staff training, disciplinary actions, interventions to prevent further injury/alleged abuse), a summary of the findings and a conclusion of the investigation (i.e., was the allegation substantiated or unsubstantiated). Document any notifications/referrals made as a result of the investigation (i.e., law enforcement, Board of Nursing).

This final follow-up report must be submitted to the state survey agency within five working days of the incident. The report should include **copies** of all witness statements and any additional document(s) pertinent to the thorough investigation.

Reporting Requirements

The facility **must** ensure that all allegations of abuse, neglect, injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility, the State Survey Agency, to other officials in accordance with state law, and take all necessary corrective actions depending on the results of the investigation.

Reporting Timeframes

All allegations of abuse, neglect, misappropriation of resident property, including injuries of unknown source must be reported **immediately**. The result of facility investigations must be reported to the State Survey Agency within **five working days** of the incident.

Reporting Avenues

Reports of alleged abuse, neglect, misappropriation of resident property, and injuries of unknown source may be made by phone, email or facsimile as follows:

SCDHEC
Bureau of Certification/Health Regulations
2600 Bull Street
Columbia, S. C. 29201

Complaint Unit

803-545-4300 (Complaint Triage Unit - voicemail available)
803-545-4292 (Facsimile)
rushrf@dhec.sc.gov

A standard format for the *Initial 24-Hour Report* and a *Five-Day Follow-Up Report* is attached. The use of these forms to meet required reporting timeframes is not a requirement.

Definitions

1. *Injuries of Unknown Source* (reference **CMS S&C 05-09**)
Injuries of unknown source – Any injury should be classified as an “injury of unknown source” when **both** of the following conditions are met:
 - The source of the injury was not observed by any person **or** the source of the injury could not be explained by the resident; **and**
 - The injury is suspicious because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) **or** the number of injuries observed at one particular point in time **or** the incidence of injuries over time.
2. *Facility Reports* are official notifications to the State Survey Agency or CMS Regional Office of self-reported incidents required by federal and/or state law, regulation or policy.
3. *State Survey Agency* is the Bureau of Certification/Health Regulation, South Carolina Department of Health and Environmental Control (SCDHEC).
4. *Immediately* is defined as “without delay.” S&C 05-09 defines “immediately” as soon as possible, but not to exceed 24 hours after the discovery of the incident, in the absence of a shorter state timeframe.
5. *Complaints* are reports made to the State Survey Agency, CMS Regional Office or local Ombudsman office by any individual other than the administrator or authorized official for a provider, that alleges noncompliance with federal and/or state laws and regulations.

